	Worksheet A Cover Sheet				V2001.6	ŀ	HCFA-R-228
Line	Part I A - Organization and Plan Data		Line	Part I B - Organization and Plan Data			
#		а	#	-	а	b	С
	General Information			Non-Medicare Cost Information	Base	Contract	Two-Year
1	Name of M+C Plan (Enter Below)				Period (\$PMPM)	Period (\$PMPM)	Trend
			1	Collections from Enrollees/Initial Rate			No trend
2	Org. #		2	Direct Medical Care			No trend
3	H #		3	Administration			No trend
4	Plan ID		4	Additional Revenue			N/A
5	Type of Plan	Select Choice		Organization Name & Plan Contact			
6	Enrollee Type (Part A/B or Part B-only)	Select Choice	5	Name of M+C Organization			
7	ACR Contract Year	2001	6	Plan Contact Person Name and Position			
8	Average Payment Rate (\$PMPM)		7	Plan Contact Person Telephone Number			
9	Contribution to Stabilization Fund (\$PMPM)		8	Plan Contact Person E-mail Address			
10	Number of Years to Hold Stabilization Fund						
11	Medicare Deductibles and Coinsurance (\$PMPM)	98.74		Part III Summary of M+C Enrollee Cha	arges from Worl	ksheet C (\$PMP	PM)
12	Medicare Psychiatric Co-payment (\$PMPM)	1.92	Line		Premium	Cost	Total
	Enrollment Information		#	·		Sharing	Charges
13	Medicare Enrollee Capacity		1	Basic + Mandatory Supplemental Benefits			
14	Non-Medicare Enrollee Capacity			Sum of Optional Supplemental Benefits			
15	Projected Average Monthly Medicare Membership			· · · · · · · · · · · · · · · · · · ·	•		
16	Projected Avg. Monthly Non-Medicare Membership						
17	Delegation of Authority to Submit Certain Changes	Select Choice	Cert	ification:			
			1	hereby certify that I have examined the acc	ompaning Adju	sted Community	Rate
Line	Part II - M+C MSA Supplemental Data		prop	oosal and attached worksheets for the contra	act period identi	fied in Part IA, li	ne 7. To the
#		а	best	of my knowledge and belief, this proposal of	ontains true an	d correct statem	ents
1	Annual Deductible (\$)			pared from the books and records of the con			
2	M+C MSA Premium (\$PMPM)			icable instructions, except as noted. In add			
3	M+C MSA Supplemental Premium (\$PMPM)			Plan Benefit Package form submitted for the			Ü
	Actuarial Val. Supp. Benefit Cost Sharing (\$PMPM)			Ü		•	
5	Amounts Collected in Previous Period (\$PMPM)						
	· · · · · ·		I1	f "yes" appears on line 17, Part IA, the plan	contact person	named on line 6	, Part 1B, is
				orized to submit selected changes (as listed			
				ű (,	
		Date					
	Vice President, Marketing	•					
						Date	
				Chief Executive Officer	•		
		Date					
	Chief Financial Officer	•			OMB Control N	Number (0938-0	742)

	Worksheet A1 Service Area and Estimate of Annual Payment Rate									Enr	ollee Type:	
Part I -	Rate of Change in H# Risk	Factors		Part II - Ca	Iculation of	Plan Annua	l Payment F	Rate (APR)				
	CY 2000 Risk Factor =	1.0000			Number of	Counties in	this Plan =	0		Name of M	+C Plan	
	CY 2001 Risk Factor =	1.0000		CY 20	01 Total Es	timated Me	mbership =	0				
C	% Change in Risk Factor =	0.00%				timated Pay		0		Org. #:	H#:	Plan ID:
				CY	2001 Estin	nated APR ((\$PMPM) =					
Part III -	Plan Service Area and Ca			ounty		1				1		
		CY 2000	CY 2000		CY 2001	Est.		CY 2001		CY 2001		CY 2001
		Actual	HCFA		HCFA	County		Estimated	Plan-	Estimated	CY 2001	Estimated
_		Monthly	County		County	APR		County	Level	County	Est.	Total
State-		Payment	Payment	Column c	Payment	Before Risk	% Change	APR With	Adjust-	APR	Average	Payment
County	_	Rate	Rate	divided by	Rate	Adj	in Risk	Risk Adj.	ment	(\$PMPM)	Member-	(\$)
Code	County Name	(\$PMPM)	(\$PMPM)	Column d	(\$PMPM)	(\$PMPM)	Factor	(\$PMPM)	(\$PMPM)		ship	(k times I)
а	b	С	d	е	f	g	h	i	j	k	I	m

	Worksheet B Base Period Costs pe	er Member-Mon	th	Enrollee Type):	Begin Date	
Nam	ne of M+C Plan:	Type:	Org. #:	H#:	Plan ID:	End Date	
		Total	Basi	c Benefits	Supplemen	ital Benefits	
Line	Health Care	Medicare	Medicare-	Additional	Mandatory	Optional	
#	Components	Enrollee	Covered	Benefits	Supplemental	Supplemental	
	Base Period	Costs	Benefits		Benefits	Benefits	
		а	b	С	d	е	
1	Inpatient Hospital Services						
2	Skilled Nursing Services						
3	Rehab. Services (CORF)						
4	ER/Post Stab./Urgent Care						
	Partial Hospitalization						
	Home Health						
7	Health Care Professionals						
	Clin./ Diag./Therap. Rad. Lab						
9	Outpatient Hospital Services						
	Ambulance/Transportation						
	DME						
	Renal Dialysis						
	Other						
	Preventive Services						
15	Outpatient Drugs/Prescription Drug						
	Dental						
	Eye Exams/Wear						
	Hearing Exams/Aids						
	POS						
	COB-Working Medicare						
	COB-Other						
	Subtotal - Direct Medical Care						
	Administration						
	Additional Revenue						
25	Total						
	Amounts Collected from Members						
30	Enrolled Member-Months						

Worksheet B1 Base Period Financial	Data		Enrollee Type	
Name of M+C Plan	Type:	Org. #:	H#:	Plan ID:
FISC	AL SOUNDNESS RATIOS	AND RELATED FINA	ANCIAL INFORM	ATION
Line	Prior Period	Base Period	Change	% Change
# Indicators	1998	1999	(b - a)	(c / a)
	а	b	С	d
Performance Indicators				
1 Net Worth (dollars)				
2 Total Revenue (dollars)				
3 Operating Revenue (dollars)				
4 Operating Profit of Loss (dollars)				
5 Net Profit or Loss (dollars)				
6 Medical Expense Ratio				
7 Administrative Expense Ratio				
8 Overall Expense Ratio				
9 Operating Profit Margin				
10 Overall Profit Margin				
11 Debt-to-Service Ratio				
Liquidity Indicators				
12 Current Ratio				
13 Cur. Assets + Long-Term Bonds/Cur. L	iab.			
14 Days Cash on Hand				
15 Cash-to-Claims-Payable Ratio				
Efficiency Indicators				
16 Days in Premiums Receivables				
17 Days in Unpaid Claims				

	Worksheet C Premiums & Cost Sha	aring (in Dollar	s per Membe	er per Month)		Er	rollee Type:	
	Name of M+C Plan	Type:	Org. #:	H#:	Plan ID:			
		71-	- 3					
		Medicare-	Additional	Mandatory	Optional	Optional	Subtotal	Medicare
		Covered	Benefits	Supplemental	Supplemental	Supplemental	Optional	Enrollee
		Benefits		Benefits	Benefits	Benefits	Benefits	Total
	Health Care					Premiums	Charges	Charges
Line	Components						(d + e)	(a+b+c+f)
#	Contract Period						(4 : 5)	(0.101011)
		а	b	С	d	е	f	g
1	Inpatient Hospital Services							
2	Skilled Nursing Services							
	Rehab. Services (CORF)							
4	ER/Post Stab./Urgent Care							
5	Partial Hospitalization							
6	Home Health							
7	Health Care Professionals							
8	Clin./ Diag./Therap. Rad. Lab							
	Outpatient Hospital Services							
	Ambulance/Transportation							
	DME							
	Renal Dialysis							
	Other							
	Preventive Services							
	Outpatient Drugs/Prescription Drug							
	Dental							
	Eye Exams/Wear							
	Hearing Exams/Aids							
	POS							
	COB-Working Medicare							
	COB-Other							
	Subtotal - Direct Medical Care							
	Administration							
	Additional Revenue				•			
	Total Cost-sharing Charge							
	Premium to be Charged							
27	Total Charges							

	Worksheet D Expected Cost and \	Er	rollee Type							
	<u> </u>									
	Name of M+C Plan		Type	Org. #:	H#	Plan ID				
									1	
		Trended	Adjusted	Trended	Adjusted	Trended	Adjusted	Trended	Adjusted	Adjusted
		Value	Value	Value	Value	Value	Value	Value	Value	Value
		Medicare-	Medicare-	Additional	Additional	Mandatory	Mandatory	Optional	Optional	Total
	Health Care Components	Covered	Covered	Benefits	Benefits	Supp.	Supp.	Supp.	Supp.	Benefits
Line	Contract Period	Benefits	Benefits			Benefits	Benefits	Benefits	Benefits	
#		а	b	С	d	е	f	g	h	İ
	Inpatient Hospital Services									
	Skilled Nursing Services									
	Rehab. Services (CORF)									
	ER/Post Stab./Urgent Care									
	Partial Hospitalization									
	Home Health									
	Health Care Professionals									
	Clin./ Diag./Therap. Rad. Lab									
	Outpatient Hospital Services									
	Ambulance/Transportation DME									
	Renal Dialysis									
	Other									
	Preventive Services									
	Outpatient Drugs/Prescription Drug									
	Dental									
	Eye Exams/Wear									
	Hearing Exams/Aids									
	POS									
_	COB-Working Medicare									
	COB-Other								1	
	Subtotal - Direct Medical Care									
	Administration									
	Additional Revenue									
	Total									

	Worksheet E Adjusted Community Rate (in Dollars per Mei	mber per Month)		Enrollee Type:		
	Name of M+C Plan:	Type:	Org. #:	H#:	Plan ID:		
Line	Part I	Adjusted	Amt. of		Comment		
#	Standard Benefit Package	Costs	Error Msg.				
			in Col. a.				
		a.	b.		C.		
1	Average Payment Rate			Imported fron	n Worksheet A - Cover		
	Medicare-Covered Benefits						
	Direct Medical Care				n Worksheet D - Exp Var.		
	Administration			Imported fron	n Worksheet D - Exp Var.		
	Additional Revenue				n Worksheet D - Exp Var.		
	Adjusted Community Rate			Sum of lines			
6	Less: Medicare Ded.and Coinsurance	98.74		Imported from	n Worksheet A - Cover		
7	Medicare Psychiatric Co-payment	1.92		Imported from	n Worksheet A - Cover		
8	Adjusted ACR			Remainder (L	ine 5-Lines 6&7)		
	Excess Amounts				Line 1 - Line 8)		
10	Less: Contributions to Stabilization Fund				m Worksheet A - Cover		
11	Adjusted Excess Amounts			Remainder (L	Line 9 - Line 10)		
	Additional Benefits						
12	Direct Medical Care			Imported from	n Worksheet D - Exp Var.		
13	Administration			Imported from	n Worksheet D - Exp Var.		
	Additional Revenue				n Worksheet D - Exp Var.		
15	Total Additional Benefits			Sum of lines	12-14		
16	Remaining Excess			Remainder (Line 11 - Line 15)		
	Maximum to be Charged - Basic						
17	Medicare Deductibles and Coinsurance	98.74		Amount from	Line 6		
	Medicare Psychiatric Co-payment	1.92		Amount From			
19	Less: Remaining Excess			Amount From	Line 16		
	Maximum to be Charged	100.66		Remainder (L	ine 17+Line 18) - Line 19		
21	Actual Charge (WKS C Ln 27 Cols a+b)						
	Mandatory Supplemental Benefits						
	Direct Medical Care						
23	Administration						
	Additional Revenue						
	Total Mandatory Supplemental Benefits						
	Actual Charges (WKS C Line 27 Col d)						
27	Total Charges						

	Worksheet E Adjusted Community Rat	e (in Dollars per M	ember per Mont	h)		Enrollee Type:]
	Name of M+0	C Plan:		Туре:	Org. #:	H#:	Plan ID:		
Line #	Part II Optional Supplemental Benefits	Trended Value of Benefit Wks D	COB, Admin & Revenue Allocation b	ACR Before Adjustment (a + b)	Expected Variation Wks D d	ACR/ Maximum Charge	Less Cost Sharing Wks C	Premiums (e - f)	Amt. of Error Msg. col. e
2	Inpatient Hospital Services Skilled Nursing Services	а	D	С	u	e	ı	g	ri
4	Rehab. Services (CORF) ER/Post Stab./Urgent Care Partial Hospitalization								
7	Home Health Health Care Professionals								
9	Clin./ Diag./Therap. Rad. Lab Outpatient Hospital Services Ambulance/Transportation								
11 12	DME Renal Dialysis								
14	Other Preventive Services Outpatient Drugs/Prescription Drug								
16 17	Dental Eye Exams/Wear								
	Hearing Exams/Aids POS								
21 22	COB-Other Subtotal - Direct Medical Care Administration								
24	Additional Revenue Total								

	Worksheet C1 Part B-Only Maximum Charge for	Part A Bene				Enrollee Type:	
	Name of M+C Plan	Type:	Org. #:	H#:	Plan ID:		
	THE MAXIMUM ALLOWABLE CHARGE TO PART OF THE 3 VALUES LISTED BELOW .	B-ONLY EN	ROLLEES FO	OR PART A B	ENEFITS IS	THE LESSER	
Line		em				Α	В
1	Value 1. ACR value of Part A benefits provide	d in this plar	n (ENTER VA	LUE)			
2	Value 2. Sum of the APR for Part A benefits, t deductible and coinsurance and the ACR value				Α		
3	APR for Part A benefits (ENTER VALUE)						
4	+ Actuarial value of Part A deductible and	coinsurance				\$28.05	
5	+ ACR value of Medicare Part A coordination VALUE)	on of benefit	s for working	aged (ENTE	ĒR		
6	Value 2 Total (Sum of lines 3, 4, and 5)						
7	Value 3. Sum of the amount Medicare would of qualified plus the actuarial value of Part A dec	•			idual not		
8	Amount Medicare would charge for Part A b	enefits for ar	n individual n	ot qualified		\$310.00	
9	+ Actuarial value of Part A deductible and co	oinsurance				\$28.05	
10	Value 3 Total (Sum of lines 8 and 9)						\$338.05
11	Maximum Allowable Charge. (Lesser of lines	1, 6, and 10.)				
	Enter your proposed charge to Part B-only enr must be less than or equal to line 11. If you ch the difference on Worksheet D (Expanded).			•			

	Worksheet C Premiums & Cost Sha	aring (in Dollar	s per Membe	er per Month)		Er	rollee Type:	
Ī	Name of M±C Plan	Name of M+C Plan Type: Org. #: H#: Plan ID:						
	Name of Wit O I laif	i ype.	Oig. π.	Ι Ιπ.	i iaii ib.			
Line	Health Care Components	Medicare- Covered Benefits	Additional Benefits	Mandatory Supplemental Benefits	Optional Supplemental Benefits	Optional Supplemental Benefits Premiums	Subtotal Optional Benefits Charges (d + e)	Medicare Enrollee Total Charges (a+b+c+f)
#	Contract Period	a	b	С	d	e	f	g
1	Inpatient Hospital Services	u u			u u	Ŭ	'	9
1a	Acute							
1a1	Upgrades							
1a2	Additional Days							
1b	Psych							
1b1	Additional Days							
	Skilled Nursing Services							
2a	Skilled Nursing Facility							
2a1	Non-Medicare Covered Admit.							
2a2	Additional Days							
3	Rehab. Services (CORF)							
3a	CORF							
4	ER/Post Stab./Urgent Care							
4a	ER/Post Stab. Care							
4a1	World-Wide Coverage							
4b	Urgent Care							
4b1	World-Wide Coverage							
5	Partial Hospitalization							
5a	Partial Hospitalization							
6	Home Health							
6a	Home Health Services							
6a1	Custodial Services							
6a2	Respite Care							
6a3	Homemaker Services							
7	Health Care Professionals							
7a	Primary Care							
7b	Chiropractic Services							
7b1	Routine Care							
7c	Occupational Therapy Services		-					-
7d	Phys. Spec. Svcs. Except Psych		-					-
7e	Mental Hlth Spec-Non -Physician							
7f	Podiatry Services							

	Worksheet C Premiums & Cost Sha	ring (in Dollar	s per Membe	er per Month)		Er	rollee Type:	
Ī	Name of M+C Plan	Type:	Org. #:	H#:	Plan ID:			
	Name of Wile Flam	турс.	01g. #.	11//.	i idii ib.			
,	Haalii Oosa	Medicare- Covered Benefits	Additional Benefits	Mandatory Supplemental Benefits	Optional Supplemental Benefits	Optional Supplemental Benefits Premiums	Subtotal Optional Benefits Charges	Medicare Enrollee Total Charges
Lino	Health Care					1 TOTTIGITIS	_	_
Line #	Components Contract Period						(d + e)	(a+b+c+f)
#	Contract Period	a	b	С	d	e	f	
7f1	Routine Care	a	D	U	u	6	ı	g
7g	Other							
7h	Psychiatric Services							
7i	Physical/Speech Therapy							
	Clin./ Diag./Therap. Rad. Lab							
8a	Outpatient Clin./Dia./Therap. Svc							
8b	Oupatient X-Ray							
	Outpatient Hospital Services							
9a	Outpatient Hospital Services							
9b	Amb. Surg. Svcs.							
9с	Outpatient Substance Abuse Svcs							
9d	Cardiac Rehabilitation Services							
10	Ambulance/Transportation							
10a	Ambulance							
10b	Transportation							
11	DME							
11a	I_I							
11b								
	Renal Dialysis							
12a	Renal Dialysis							
13	Other							
13ded	Plan Level Deductible							
13a	Blood							
13b	Acupuncture							
13c								
13d	Other 2							
13e	Other 3							
	Preventive Services							
14a	Educ./Wellness Prog.							
14a1	Classes							
14a2	Newsletters							
14a3	Nutritional Trng							

	Worksheet C Premiums & Cost Sha	aring (in Dollar	s per Membe	r per Month)		Enrollee Type:			
	Name of M+C Plan	Type:	Org. #:	H#:	Plan ID:				
Line #	Health Care Components Contract Period	Medicare- Covered Benefits	Additional Benefits	Mandatory Supplemental Benefits	Optional Supplemental Benefits	Optional Supplemental Benefits Premiums	Subtotal Optional Benefits Charges (d + e)	Medicare Enrollee Total Charges (a+b+c+f)	
π	Contract i enou	а	b	С	d	е	f	g	
14a4	Smoking Cessation	<u>~</u>	~	J	<u> </u>	- C	•	9	
14a5	Congestive Heart Failure								
14a6	Alternative Medicine Prog.								
14a7	Health Club								
14a8	Nursing Hotline	1							
14a9	Disease Mgmt								
14a10	Other								
14b	Immunizations								
14b1	Other								
14c	Routine Phys Exams								
14c1	# visits								
14d	Pap & Pelvic Exams								
14d1	Pap Smears								
14d2	Pelvic Exams								
14e	Prostate Screening								
14e1	Additional Screenings								
14f	Colorectal Screening								
14f1	Additional Screenings								
14g	Bone Mass Measurement								
14h	Mammography Screening								
14h1	Additional Screenings								
14i	Diabetes Monitoring								
	Outpatient Drugs/Prescription Drug								
15a	Outpatient Drugs								
	Dental								
16a	Preventative Services								
16a1	Prophylaxis (cleaning)								
16a2	Flouride Treatment								
16a3	Dental X-rays								
16a4	Oral Exams								
16b	Comp. Svcs								
16b1	Emergency Services								

	Worksheet C Premiums & Cost Sha	Enrollee Type:						
	Nome of M. C. Play	T						
	Name of M+C Plan	Type:	Org. #:	H#:	Plan ID:			
		Medicare-	Additional	Mandatory	Optional	Optional	Subtotal	Medicare
		Covered	Benefits	Supplemental	Supplemental	Supplemental	Optional	Enrollee
		Benefits	Deficitio	Benefits	Benefits	Benefits	Benefits	Total
	Llockh Core	Deficites		Deficites	Deficitio	Premiums	Charges	Charges
Lina	Health Care					1 TCITIGITIS	_	_
Line	Components						(d + e)	(a+b+c+f)
#	Contract Period		b		۵		f	~
16b2	Diagnostic Services	а	D	С	d	е	ı	g
16b2	Restorative Services	1						
16b4	Endo/Perio/Extractions	-						
16b5	Prostho, Oral Surgery, Other	-						
	Eye Exams/Wear							
17a	Exams							
17a1	Routine							
17b	Wear							
17b1	Contact Lens							
17b2	Lens and Frames							
17b3	Lenses							
17b4	Frames	1						
17b5	Upgrades							
18	Hearing Exams/Aids							
18a	Exams							
18a1	Routine Hearing Tests							
18a2	Fit & Eval. For Hearing Aid							
18b	Aids							
18b1	# - Inner Ear							
18b2	# - Outer Ear							
18b3	# - Over the Ear							
18b4	# - Replacement Batteries							
	POS							
	COB-Working Medicare							
	COB-Other							
	Subtotal - Direct Medical Care							
	Administration							
	Additional Revenue							
	Total Cost-sharing Charge							
	Premium to be Charged							
27	Total Charges							

	Worksheet D Expected Cost and Variation (in Dollars per Member per Month)						Enrollee Type			
	Name of M+C Plan Type Org. #: H#				Plan ID					
	Name of Mito Flam		туре	Olg. #.	1 1#	FIAITID				
Line	Health Care Components Contract Period	Trended Value Medicare- Covered Benefits	Adjusted Value Medicare- Covered Benefits	Trended Value Additional Benefits	Adjusted Value Additional Benefits	Trended Value Mandatory Supp. Benefits	Adjusted Value Mandatory Supp. Benefits	Trended Value Optional Supp. Benefits	Adjusted Value Optional Supp. Benefits	Adjusted Value Total Benefits
#		а	b	С	d	е	f	g	h	i
	Inpatient Hospital Services									
1ev	Expected Variation									
	Skilled Nursing Services									
2ev	Expected Variation									
3	Rehab. Services (CORF)									
3ev	Expected Variation									
4	ER/Post Stab./Urgent Care									
4ev	Expected Variation									
5	Partial Hospitalization									
5ev	Expected Variation									
6	Home Health									
6ev	Expected Variation									
7	Health Care Professionals									
7ev	Expected Variation									
8	Clin./ Diag./Therap. Rad. Lab									
8ev	Expected Variation									
9	Outpatient Hospital Services									
9ev	Expected Variation									
10	Ambulance/Transportation									
10ev	Expected Variation									
11	DME									
11ev	Expected Variation									
12	Renal Dialysis									
12ev	Expected Variation									
13	Other									
13ev	Expected Variation									
	Preventive Services									
14ev										
15	Outpatient Drugs/Prescription Drug									
	Expected Variation									
	Dental									
16ev										
	Eye Exams/Wear									

	Worksheet D Expected Cost and Variation (in Dollars per Member per Month)					Enrollee Type				
	Name of M+C Plan		Туре	Org. #:	H#	Plan ID				
Line	Health Care Components Contract Period	Trended Value Medicare- Covered Benefits	Adjusted Value Medicare- Covered Benefits	Trended Value Additional Benefits	Adjusted Value Additional Benefits	Trended Value Mandatory Supp. Benefits	Adjusted Value Mandatory Supp. Benefits	Trended Value Optional Supp. Benefits	Adjusted Value Optional Supp. Benefits	Adjusted Value Total Benefits
#		а	b	С	d	е	f	g	h	i
17ev										
18	Hearing Exams/Aids									
18ev	Expected Variation									
19	POS									
19ev	Expected Variation									
20	COB-Working Medicare									
20ev	Expected Variation									
21	COB-Other									
21ev	Expected Variation									
22	Subtotal - Direct Medical Care									
23	Administration									
23ev	Expected Variation									
24	Additional Revenue									
24ev	Expected Variation									
25	Total				_		_			_